

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 3.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					80 29650
					REG. NO.
1. FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH MONTH DAY YEAR	
	FIRST MIDDLE LAST JEANNETTE B. Cross			11-24-80	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		2b. HOUR	
F	WHITE	SEPT. 18, 1906		2:00 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
MD.	U.S.A.	74		IF UNDER 24 HRS HOURS MIN.	
7c. YRS	9. BALTIMORE CITY OR COUNTY OF DEATH		9. BALTIMORE CITY OR COUNTY OF DEATH		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN A HOSPITAL, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
CHESTER		RT. #7 BOX 426		HOUSEWIFE	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS
MD.		QUEEN ANNES	CHESTER	RT. #7 BOX 426	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. SOCIAL SECURITY NO.	
WILLIAM P. BEALL		HANNAH CARDWELL		218-40-8259	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS	
NO		ELEANOR CROSS		SAME. 21619	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary artery Disease			
4149					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b)			
		DUE TO, OR AS A CONSEQUENCE OF (c) atherosclerosis			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
Cerebrovascular Disease; Old CVA.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 1978, 19, to 11-24, 1980, that (I/we) last saw the deceased alive on 11-22, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.					
22b. SIGNATURE T. Detrich		22c. DEGREE M.D.		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. ADDRESS T. Detrich, M.D.		22f. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11-28-80	23c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEM.	23d. LOCATION CITY OR TOWN BALTIMORE CO. MD	
24. FUNERAL DIRECTOR NAME NEVELL F.H. REISTERSTOWN RD		25. DATE REC'D. BY REGISTRAR DEC 1 1980			

FOOT ON ROAD

ON ROAD

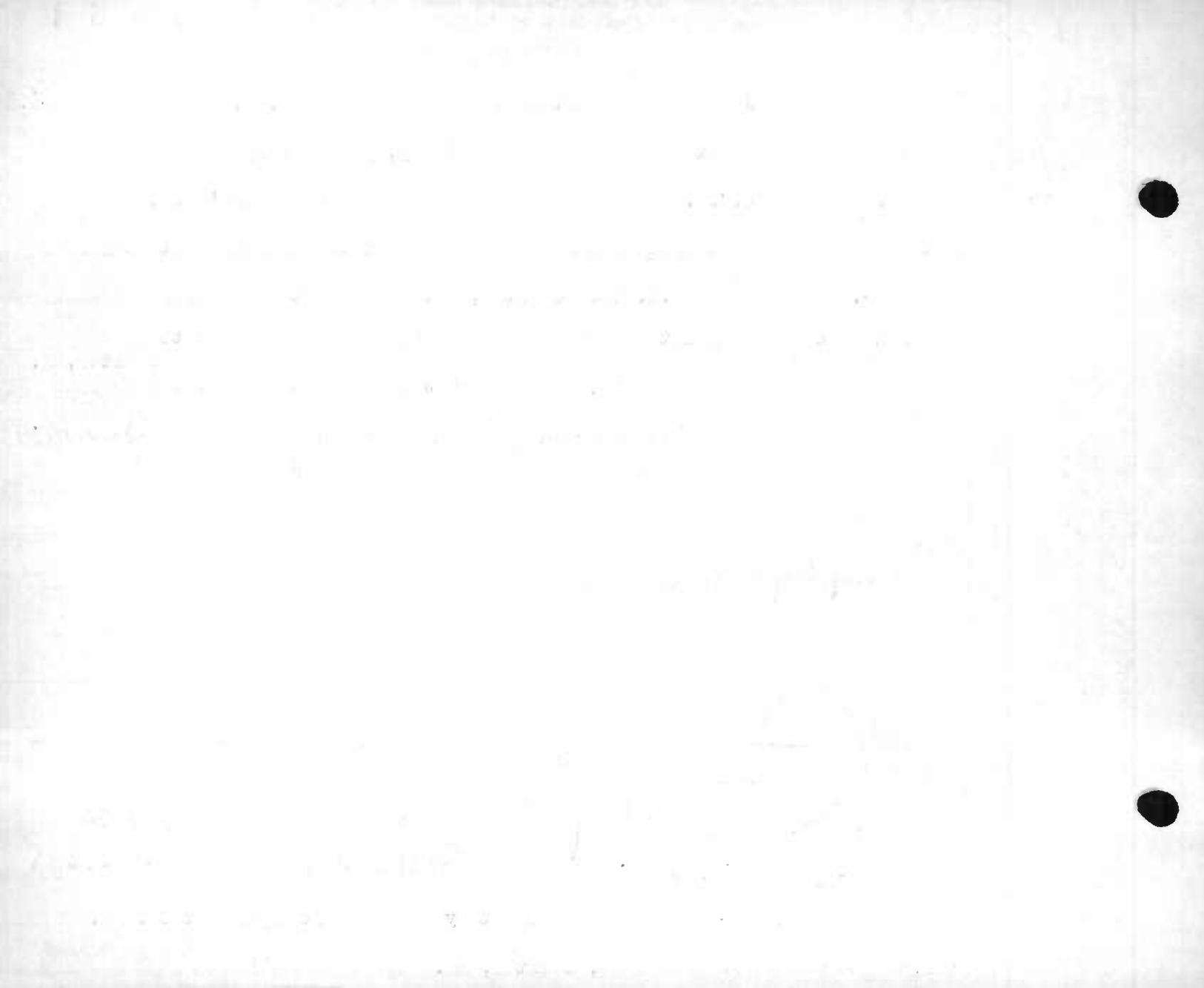
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 9 6 5 1  
CERTIFICATE OF DEATH

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month	Doy	Year	2b. HOUR 60 M	
			William	Joseph	Heisterhagen	Nov.	2, 1980			
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (in years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
male		white	April 25, 1901			79	YRS.			
7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Md.		U.S.A.			Queen Anne's Co., Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Centreville		Corsica Hills Nursing Home			Truck Driving route salesman					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Md.		Q.A. Co.			Chester, Md.		Rt#1 Box #526			
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle	Lost	
		Frederick		Heisterhagen			Sophie		Rott	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.			17. INFORMANT		Address			
no		140-07-9998			William Joseph Heisterhagen, Rt#1 Box#526		Chester, Md.			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
June 1979										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the Lung</i>										
1629 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (last). (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town	County	State	
22a. I certify that (I) (This hospital) attended the deceased from 12, 1971, to 11-2, 1980, that (I) (we) last saw the deceased alive on 11-1, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE		<i>Libby</i>			MD. DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 11-7-80	
22d. PHYSICIAN'S NAME (Type)		Dr. Ralph Libby, Md.			22e. ADDRESS		GRASONVILLE, MD 21638			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City or Town) Easton		(County) Talbot Co. Md. (State)	
Burial		10-5-80		Woodlawn Cemetery						
24. FUNERAL DIRECTOR		ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
		21619					<i>Ralph Libby</i>			
					DATE		NOV 10 1980			
		Helfenbein-Hubbard Funeral Home, Chester, Md.								



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retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8029652			
										REG. NO.			
1 - STATE REGISTRAR			2. DATE OF DEATH MONTH DAY YEAR							2b. HOUR a			
I. DECEASED NAME FIRST MIDDLE LAST			11 7 80							8:04 M			
Julia Virginia Hollingsworth		J. SEX female		4. RACE caucasian		5. DATE OF BIRTH MONTH 10 DAY 20 YEAR 16			6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS				
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD Queen Anne Co.		8. CITIZEN OF WHAT COUNTRY? USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Queen Anne Co.						
10. CITY OR TOWN OF DEATH Centreville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Corsica Hills Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Maryland		13b. COUNTY QA		13c. CITY OR TOWN Church Hill			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Church Hill, Md. 21623			
14. FATHER'S NAME FIRST William		MIDDLE		LAST Walter Hollingsworth			15. MOTHER'S MAIDEN NAME FIRST Margie		MIDDLE LAST Payne				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 220-16-7668		17. INFORMANT			ADDRESS Roy Payne Church Hill Md. 21623			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos.			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1552 Carcinoma of Liver DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from July 1, 1980, to Nov. 11, 1980, that (II) (we) last saw the deceased alive on 11-7-1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE John R Smith, Jr.		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 11/11/80						
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS Centreville, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-10-80			23c. NAME OF CEMETERY OR CREMATORIUM Chesterfield Cemetery			23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Centreville Queen Anne Md.													
24. FUNERAL DIRECTOR NAME Helfenbein-Hubbard Funeral Home Chester, Md.		25a. DATE REC'D. BY REGISTRAR 210 Nov 17 1980			25b. REGISTRAR'S SIGNATURE Ricky McCloud								

W



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 80 29653	
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 11-24-80							2b. HOUR 1 P.M.	
1c. DECEASED NAME FIRST MIDDLE LAST JAMES PALMER JARRELL			5. DATE OF BIRTH MONTH DAY YEAR 1 12 02			6. AGE (IN YEARS LAST BIRTHDAY) 78			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
3. SEX MALE			4. RACE II			7b. CITIZEN OF WHAT COUNTRY? U.S.			9. BALTIMORE CITY OR COUNTY OF DEATH QUEEN ANNE'S MD.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			12a. USUAL OCCUPATION Carpenter			12b. KIND OF BUSINESS OR INDUSTRY Building		
10. CITY OR TOWN OF DEATH CENTREVILLE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CORSICA H. LLS Neg. Center			13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND			13b. STREET ADDRESS none		
13a. STATE MARYLAND			13b. COUNTY QUEEN ANNE'S			13c. CITY OR TOWN PRICE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME HARRY			15. MOTHER'S MAIDEN NAME ANNA			16. SOCIAL SECURITY NO. 218-16-9574			17. INFORMANT Pearl Jarrell		
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) NO			18b. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years			18c. ADDRESS Price, Md.					
<b>II CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4140</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Parkinsonism</u> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1980</u> , to <u>Nov 24, 1980</u> , that (II) (we) last saw the deceased alive on <u>Nov 24, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <u>J.R. Smith, Jr.</u>			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>11/24/80</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Smith, Jr.			22e. ADDRESS Centreville, Md 21617								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-26-80			23c. NAME OF CEMETERY OR CREMATORIALy Greensboro			23d. LOCATION CITY OR TOWN Greensboro, Caroline Md. COUNTY STATE		
24. FUNERAL DIRECTOR NAME <u>John E. Bourne's</u>			25a. DATE RECEIVED BY REGISTER 25b. REGISTRAR'S SIGNATURE <u>DEC 4 1980</u>								
ADDRESS Greensboro											



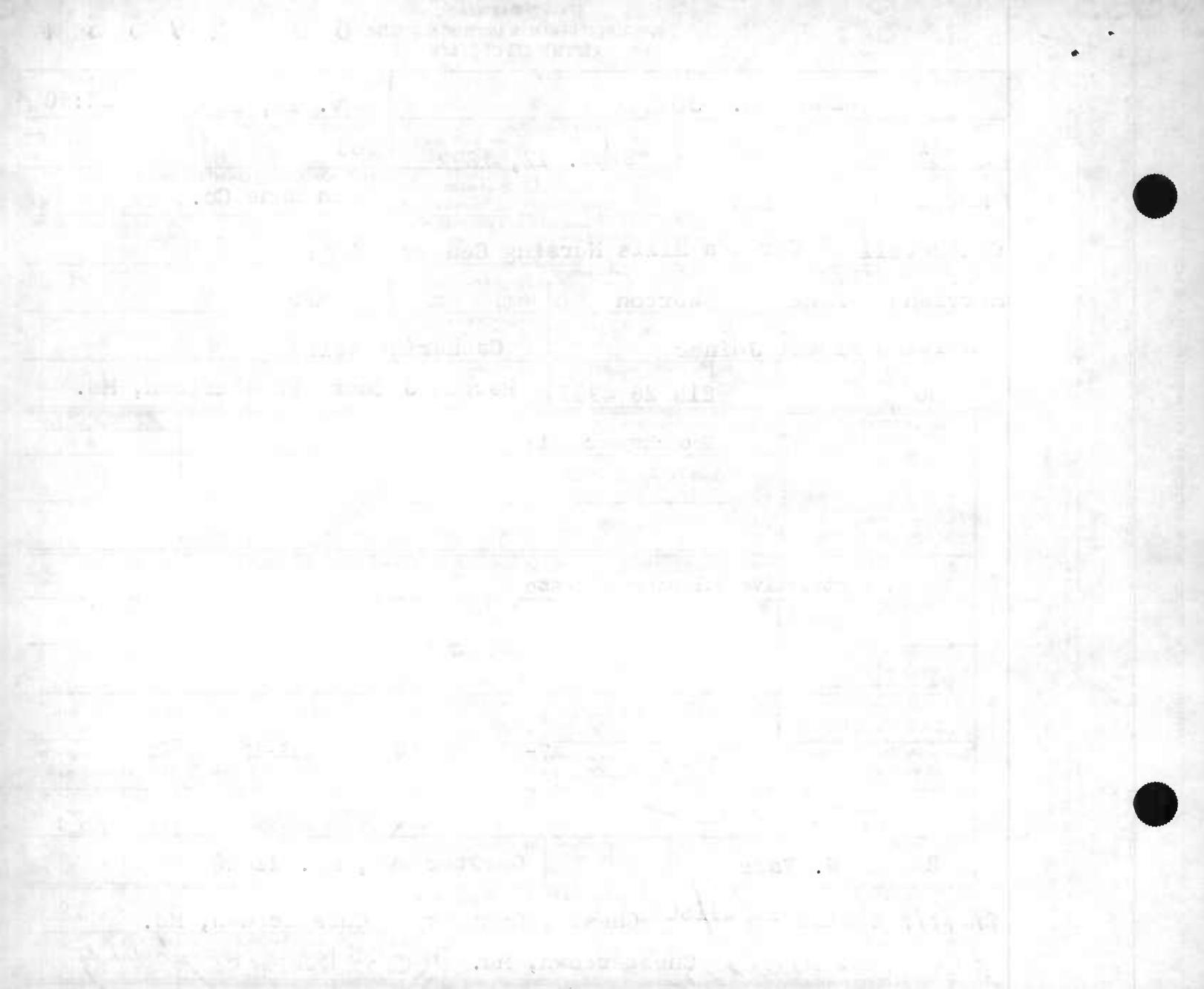
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												REG. NO.		
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS MONTHS DAYS MIN		
ALAN B. JOINER						Sept. 12, 1892			Nov. 17, 1980			12:50 A		
3 SEX male			4 RACE white			5 DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Queen Anne Co.			MD.		
10 CITY OR TOWN OF DEATH Centreville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Corsica Hills Nursing Center						12a. USUAL OCCUPATION Farmer			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Kent			13c. CITY OR TOWN Worton			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS RFD		
14. FATHER'S NAME FIRST William Albert Joiner			MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST Catherine Wells								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215 26 4957			17. INFORMANT Harold Joiner			ADDRESS Chestertown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
> 4850 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)														
{ DUE TO, OR AS A CONSEQUENCE OF (b)														
{ DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <b>ASCVd, Obstructive pulmonary disease</b>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>7-6</b> , 19 <b>74</b> , to <b>11-17</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>11-17</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we could not view the body after death, check here.)														
22b. SIGNATURE <i>Robert W. Farr</i>												DEGREE		
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												22c. DATE SIGNED <b>11/17/80</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Farr			22e. ADDRESS Chestertown, Md. 21620											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Chester Burial			23b. DATE 11/19/80			23c. NAME OF CEMETERY OR CREMATORIUM Chester Cemetery			23d. LOCATION CITY OR TOWN Chestertown, Md.			COUNTY STATE		
24. GENERAL DIRECTOR NAME <i>Willis Wells</i>			ADDRESS Chestertown, Md.			25a. DATE REC'D. BY REGISTRAR NOV 20 1980			25b. REGISTRAR'S SIGNATURE <i>Henry McCreary</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removals.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 0 2 9 6 5 5
												REG. NO.
1 - FOR STATE REGISTRAR			2a DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			Nov. 25, 1980			4 A.M.			
Margaret Van Mater Martin												
3. SEX female			4 RACE White			5. DATE OF BIRTH MONTH DAY YEAR May 20, 1902			6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.			
7a. BIRTHPLACE, STATE OR FOREIGN COUNTRY Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Queen Anne's Co.			
10. CITY OR TOWN OF DEATH Centreville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Corsica Hills Nursing Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife			12b. KIND OF BUSINESS OR INDUSTRY MD.			
13a. STATE Md.			13b. COUNTY Q.A. Co.			13c. CITY OR TOWN Chester			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Van Mater						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katrina (unknown)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 067-10-7654			17. INFORMANT Walter Litvinuck, Box F, Chester, Md. 21619			ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 1919			BRAIN STEM GLIOMA						APPROXIMATE INTERVAL BETWEEN ON-SET AND DEATH Aug. 1980			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b)									
			(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10-16 19 68 to 11-25 19 80, that (I) (we) last saw the deceased alive on 11-24 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.												
22b. SIGNATURE <i>Ralph Libby</i>			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11-26-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Ralph Libby, M.D.			22e. ADDRESS Grasonville Medical Center, Grasonville Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-29-80			23c. NAME OF CEMETERY OR CREMATORIAL Monmouth Memorial Park			23d. LOCATION CITY OR TOWN Monmouth Co. N.J.			
24. FUNERAL DIRECTOR NAME Helfenbein-Hubbard Funeral Home, Chester, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR NOV 28 1980			25b. REGISTRAR'S SIGNATURE <i>Lester H. Helfenbein</i>			

*CONFIDENTIAL*

DATE REC'D BY

SUBJ. NO. C-23-1

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3 RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 DAYS, AFTER DEATH, WITH THE STATE DIVISION OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 29656
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED	<input checked="" type="checkbox"/>	MONTH	DAY	YEAR	2b. HOUR	
Edith			M.A.Y		Weaver	11	16	19	80	1:30 a.m.		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	7d. HOUR		
Female	White	JUNE 6, 1914	66	MONTHS	DAYS	HOURS	MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH									
VIRGINIA	USA	XX	Queen Anne's County MD									
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST RECENT WORK PERIOD)	12b. KIND OF BUSINESS OR INDUSTRY									
Stevensville	Rt.1 Chesapeake Estate Box 318	HOUSEWIFE	AT HOME									
13a. STATE MARYLAND	13b. COUNTY QUEEN ANNE	13c. CITY OR TOWN STEVENSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 152 BAY DR.	#21666							
14. FATHER'S NAME FIRST UNKNOWN	MIDDLE	LAST SENATE	15. MOTHER'S MAIDEN NAME FIRST UNKNOWN	MIDDLE	LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 218-01-1866	17. INFORMANT STEPHEN DRAUN ADDRESS 631 DARIEN CT., HOFFMAN ESTATES, IL 60194										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9534 IMMEDIATE CAUSE (a) Gunshot wound of Head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:00PM 11 16 1980	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot herself										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home	21f. LOCATION STREET Box 318	CITY OR TOWN Rt. 1 Chesapeake Estate	COUNTY Stevensville	STATE Queen Anne's County, Md.							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion												
ACTUAL SIGNATURE Margarita A. Korell, M.D. TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER												
EXAMINER'S NAME Margarita A. Korell, M.D. (TYPE OR PRINT)						DATE SIGNED 11-16-80						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE 11/19/80	23c. NAME OF CEMETERY OR CREMATORIAL CHIZUK AMUNO	23d. LOCATION CITY OR TOWN BALTIMORE	COUNTY MARYLAND	STATE							
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD.	ADDRESS BALTO., MD 21215	25a. DATE REC'D. BY REGISTRAR NOV 25 1980	25b. REGISTRAR'S SIGNATURE F. J. Murphy									
BP	DHMH-17 (VR A15 ME (5)) 15M 2/80											

*reindeer*

over 5 tons